STATE OF CALIFORNIA-HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF HEALTH SERVICES
GENETIC DISEASE BRANCH

# GUIDE FOR COMPLETING THE "INSURANCE INFORMATION FORM"

Please complete the "Insurance Information Form" on the back of this Guide and return the **completed** form in the self-addressed envelope. Your insurance cannot be billed unless the form is completed and returned. Do not send a copy of your insurance card.

**MEDI-CAL PATIENTS:** Do not complete this form. Please complete the Medi-Cal information that is on bottom portion of the bill and return it in the self-addressed envelope.

**NEWBORN SCREENING: Mother is the patient.**

| PATIENT INFORMATION SECTION | |
|---|---|
| 1. Patient Insurance ID Number | If the patient is the same individual as the insured, the insurance ID number goes here. If the patient is a child, spouse or dependent, their insurance ID number goes here. The insured ID# is often referred to as the member ID #. This number should be prominent on the front of the insurance card. "Insured" is the person who has insurance coverage through their employer (this person is also known as the guarantor and is financially responsible if the insurance company does not pay the claim). |
| 2. Birth Date | Date of birth for the individual who received medical care. |
| 3. Day Phone Number | The daytime telephone number for the individual who received medical care. |
| 4. Patient Social Security Number | The Social Security Number for the individual who received medical care. If the individual does not have a Social Security Number, leave this field blank. |
| 5. Patient Name (Last) | The last name of the individual who received medical care. |
| 6. Patient Name (First) | The first name of the individual who received medical care. |
| 7. Patient Initial | The middle initial of the individual who received medical care. |
| 8. Patient Relationship to Insured | **Self**-The patient is the insured. **Spouse**-The patient is married to the insured. **Child**-The patient is the child of the insured. **Other**-Another type of dependent. |
| 9,10,11,12: Address, City, State, Zip | The physical home address of the individual who received medical care. |
| 13. Patient Marital Status | The marital status of the individual who received medical care. |

| INSURED INFORMATION SECTION | |
|---|---|
| 14. Insured Name (Last) | The last name of the individual who is insured. |
| 15. Insured Name (First) | The first name of the individual who is insured. |
| 16. Insured Initial | The middle initial of the individual who is insured. |
| 17. Insured's Sex | M = if insured is Male. F= if insured is Female. |
| 18. Insured Social Security Number | The Social Security Number for the individual who is insured. |
| 19. Insured ID Number/Military ID Number | The insured ID# is often referred to as the member ID#. This number should be prominent on the front of the insurance card. If the insured is in the military, the military ID number goes in this field. |
| 20. Insured Birth Date | The date of birth for the insured. |
| 21,22,23,24: Address, City, State Zip | The physical home address of the individual who is the insured. |

| INSURED EMPLOYER INFORMATION | |
|---|---|
| 25. Insured's Employer Name | The name of the employer where the insured works. |
| 26. Employment Relative to Insurance/Insured Employment | Check the appropriate box if the insured works full-time, part-time, not at all, self employed, retired, unknown, or on active military duty. |

| INSURANCE CLAIMS INFORMATION | |
|---|---|
| 27. Name of Insurance Carrier or Health Insurance | The name of the insurance company that will receive the claim form. |
| 28. Group Name | Typically, the group name is the medical group or the name of the employer where the insured works. |
| 29. Insured's Policy Group Number | The group number that appears on the insurance card goes in this field. The group number identifies the employer. |
| 30,31,32,33. Insurer's Claim Address City, State, Zip Code | The address for the insurance company. This usually appears on the insurance card directing claims to be mailed to that address. The city, state and zip code for the insurance company. This usually appears on the back of the insurance card directing where to mail claims for processing. |
| 34. Signature | The signature of the insured or authorized family member. |
| 35. Date | The date the form is signed. |

**PRIVACY STATEMENT**

The Information Practices Act of 1977 (Civil Code 1798 et. Seq.) requires that the State describe the procedures used to collect and safeguard private, confidential information. The Department of Health Services, Genetic Disease Branch, maintains any information supplied in response to this document. It will be used to bill insurers and apply payments. Submission of information is voluntary and is not required by law. Failure to provide the information could prevent the Department from billing your insurer. All information procured by the Department, or by any person, agency or organization acting jointly with the Department, shall be confidential. Access to these records is regulated under the provision of Article 8 of the Civil Code.